

Idaho Medicaid Health Home

Readiness Assessment

Practice Name _____

Phone _____

Street Address _____

Fax _____

City, Zip _____

Website _____

Tax ID # _____

Organizational NPI: _____

Representative for questions regarding this assessment:

Name _____ Phone _____ Email _____

Corporate Ownership or System Affiliation (if applicable) _____

INTENT

Is the practice currently participating in another medical home demonstration project (e.g. Medicare Advanced Primary Care Practice, Safety Net Medical Home Initiative)?

Yes _____ No _____ If yes, which? _____

Where is the practice in the process of transformation to a patient-centered medical home, and what does it hope to gain from participation in Health Homes? (500 words or less)

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KEY LEADERSHIP Please provide the names of key contacts for this project.

Physician Champion: Name _____ Title _____ Email _____
Office Manager: Name _____ Title _____ Email _____
Other Key Leaders: Name _____ Title _____ Email _____
Name _____ Title _____ Email _____

PRACTICE INFORMATION

1. How often and with whom does your practice have regular meetings?

Format:	How often?	Circle the topics addressed:
___ Clinicians only	_____	Policies/Procedures Finances Clinical Other
___ Staff only	_____	Policies/Procedures Finances Clinical Other
___ Clinicians & staff together	_____	Policies/Procedures Finances Clinical Other
___ Other (please list below):	_____	Policies/Procedures Finances Clinical Other

2. Has your practice completed any practice transformation readiness evaluations?

TransforMed MHIQ ___ NCQA ___ URAC ___ PCMH-A (Qualis)___ Metric (AAFP) ___ EQUIPP (AAP) ___
Medical Home Builder (ACP)___ Other _____

3. Practice Type Family Medicine ___ Internal Medicine ___ Pediatric ___

Physicians	Full-time _____	Part-time _____	Total FTEs _____
Mid-level (PA, NP)	Full-time _____	Part-time _____	Total FTEs _____
Practice staff	Full-time _____	Part-time _____	Total FTEs _____

4. What percentage of your patient population is Medicaid: _____%

5. Average patient panel size

Per primary care physician _____ Per mid-level provider _____
Approximate number of patient visits per year for all providers _____
Number of patients who made at least one visit to the clinic last year _____

HEALTH INFORMATION TECHNOLOGY CAPABILITIES

1. Does practice have an electronic medical record system? Yes ___ No ___

If yes, what system? _____ For how long? _____

2. Does practice use a registry or electronic medical record to track patients with specific conditions?

Yes ___ No ___ If yes, for which conditions? _____

3. Is practice able to send and receive data (e.g. labs, imaging results) electronically with other healthcare organizations (hospitals, testing providers, specialists)? Yes ___ No ___

If yes, via what method (e.g. secure email, Idaho Health Data Exchange, linked electronic medical records):

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QUALITY IMPROVEMENT

1. **Does practice conduct formal quality improvement activities?** Yes ____ No ____

If yes, specify tool (e.g. Six Sigma, Lean, PDSA cycles, other): _____

2. **Does practice currently track any clinical or service quality measures?** Yes ____ No ____

a. If yes, list what measures and how often they are reviewed:

Measure _____ Frequency _____

Measure _____ Frequency _____

Measure _____ Frequency _____

Measure _____ Frequency _____

Measure _____ Frequency _____

Measure _____ Frequency _____

b. Describe how the practice has implemented a quality improvement strategy based on one of these measures. Include information on the style of decision making in the practice, how progress was measured, what challenges were encountered, etc.: (500 words or less)

- c. Do quality improvement activities include: (circle Y or N)

Setting goals based on measurement results Y N

Taking action to improve performance of providers Y N

Taking action to improve performance of practice Y N

Patient/consumer representatives on QI Committee Y N

Board member on QI Committee Y N

Staff member with dedicated time for QI activities Y N

Involvement of clinicians on QI Committee Y N

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2. **Does the practice currently track any practice transformation measures** (empanelment, open access, etc.)?

Yes ____ No ____

a. If yes, list what measures and how often they are reviewed:

Measure _____ Frequency _____

Measure _____ Frequency _____

Measure _____ Frequency _____

b. Describe how the practice has implemented a practice transformation strategy based on one of these measures. Include information on the style of decision making in the practice, how progress was measured, what challenges were encountered, etc.: (500 words or less)

3. **Does practice measure patient satisfaction?**

Yes ____ No ____ How often _____

4. **Does practice measure staff and/or provider satisfaction?**

Yes ____ No ____ How often _____

Care Plans (see provider handbook for care plan guidelines at www.idmedicaid.com)

1. As required by Medicaid, each Health Home participant is required to have an established care plan. How does your clinic intend to meet this requirement?

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2. What is the suggested timeline your clinic has set to achieve this requirement?

The Idaho Medicaid Health Home model is open to *all* Healthy Connection primary care providers. Providers must have 46 hours of access and be enrolled as a Healthy Connections provider to participate in Medicaid Health Homes. Providers will also be required to sign a provider addendum in order to receive payments for participation in Medicaid Health Homes. The provider agreement will outline all Health Home requirements providers must meet to receive payments. A per member per month incentive in the amount of \$15.50 will be given for meeting the outlined requirements.

Please fax the Health Home Readiness Assessment to the Health Home team at 1-208-364-1811. The Health Home practice facilitators will contact you upon review of the assessment.

For questions regarding the readiness assessment, please contact:

Idaho Medicaid Health Home Program

Heather Clark-- 208-364-1863

Donna Colberg - 208-665-8846

Meg Hall - 208-665-8844

medicaidhealthhome@dhw.idaho.gov